



## To Tame a Shark, Feed it Sacred Cows

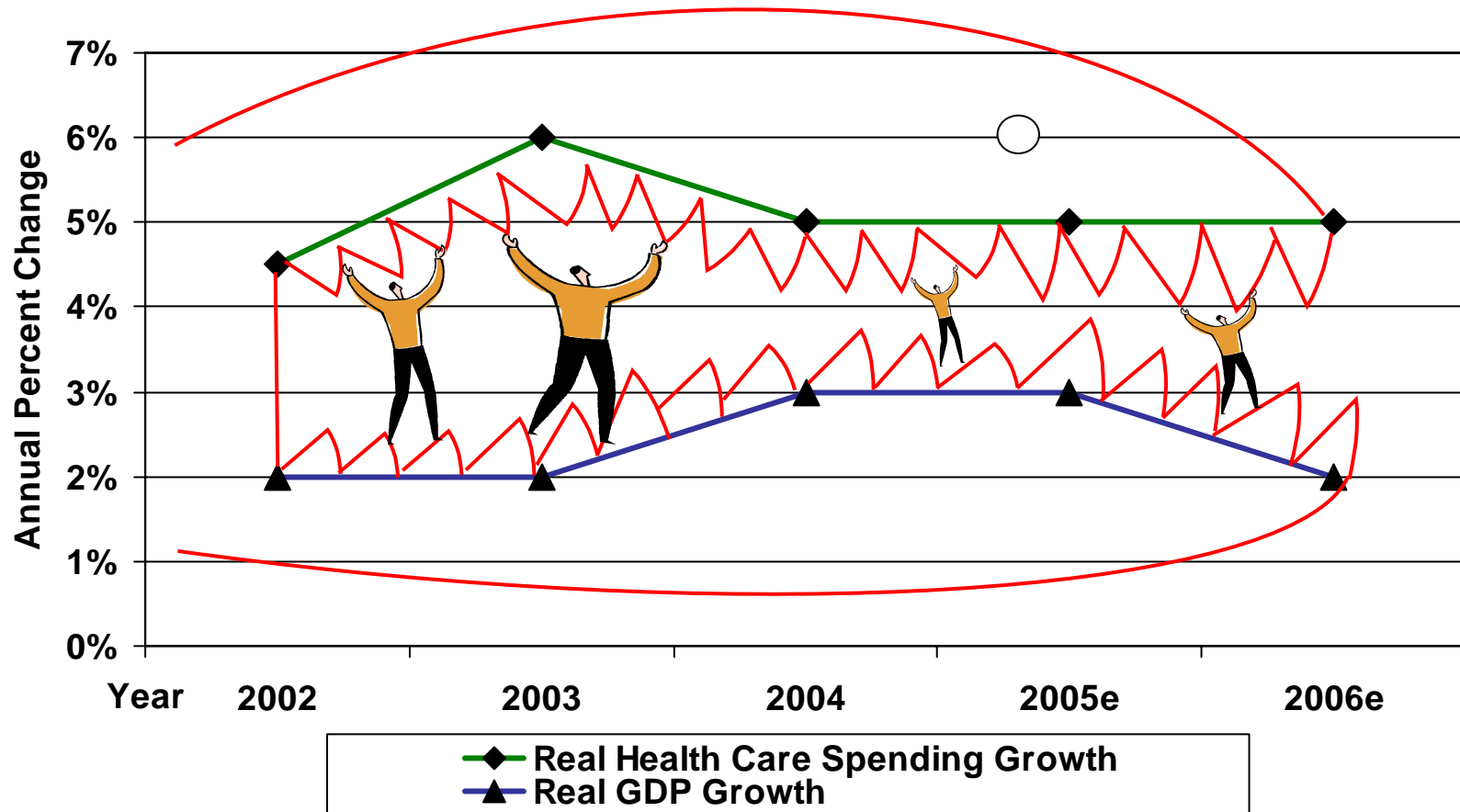
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**Medical Director, Pacific Business Group on Health**

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# The Irresistible Menace that Motivated the IOM to Deem Provider Efficiency "P4P-Critical"

Annual Percent Changes per Capita in Health Care Expenditures and in GDP



Data from Borger et al, *Health Affairs Web Exclusive*, "Health Spending Projections Through 2015: Changes on the Horizon," 2/2006. Dental work by Dr. Milstein.



# Why Relying on the Generosity of Others Is Not (and Cannot be) a Long-Term Sole Solution to Health Care Affordability

	Total	All Adults
<b>If the only way to make sure that everyone can get the health care services they need is to have a substantial increase in taxes, we should do it.</b>	<b>Agree</b>	<b>28%</b>
	<b>Disagree</b>	<b>42%</b>
	<b>Not Sure/ Decline to Answer</b>	<b>29%</b>

Extracted from a HarrisInteractive health care poll as reported in WSJ Health-Care Poll, July 31, 2006



NY Times © 2006

**America's growing fraction of service workers – under dual stresses**



## Challenging Design Questions in Efficiency-Based P4P: Customer & Provider Perspectives Diverge

- **Customer or Provider Determination of Minimum Validity?**
- **Fast or Slow Provider Efficiency Transparency?**
- **Comprehensive or Narrow Efficiency Measures?**
- **MD Group & Individual MD Measurement or MD Group Only?**
- **Real or Standardized Prices?**
- **Quality Balanced or Quality Matched?**
- **Electronic or Paper Data Sources?**
- **Steep or Gentle P4P/Efficiency Slope?**

**(Researchers are split, except on first question)**



## Continuously Improving Quality of Products and Services Needn't Cost More

**% of average U.S. household income needed to buy an average car\***

1991 Car	2006 Car
<b>30 weeks of income</b>	<b>24 weeks of income</b>

\*Auto Affordability Index, <http://www.Comerica.com>, accessed January 22, 2007.



## To Afford Wider Insurance Coverage *and* a Continual Inflow of Medical Miracles, P4P & Other Tools Need to Do 2 New Jobs

- Lower total cost of care by 40 percentage points from average levels to current benchmark levels (↑↑ “translational efficiency”)
- Lower total cost of care by >2.5 percentage points in every year (↑↑ “knowledge turns”)



**Clinical efficiency =  
health gain/total cost of care**



# Translational Efficiency Opportunity to Reduce Total Cost of Care & Improve Quality: In Diabetes, BP Control is the Clear Winner

Care Delivery Improvement <sup>1</sup>	Cost Complications (\$)*	Cost Intervention (\$)*	Quality-Adjusted Life-Years (QALYs)*	Incremental Cost-Effectiveness Ratio (Total Cost/QALY) (\$)
Intensive glycemic control**	-4,330	12,213	0.1915	41,384
Intensive hypertension control***	-4,836	3,708	0.3962	-1,959
Reduction in serum cholesterol levels****	1,687	15,942	0.3475	51,889

\* Discounted at 3% annual rate. Costs are for patient's lifetime and are reported in 1997 dollars.

\*\* All patients who were newly diagnosed as having type 2 diabetes.

\*\*\* All patients who were newly diagnosed as having type w diabetes and hypertension.

\*\*\*\* All patients who were newly diagnosed as having type 2 diabetes and above normal serum cholesterol level.

<sup>1</sup> "Cost-Effectiveness of Intensive Glycemic Control, Intensified Hypertension Control, and Serum Cholesterol Level Reduction for Type 2 Diabetes," The CDC Diabetes Cost-Effectiveness Group, Hoerger, T. et al, JAMA, May 15, 2002.

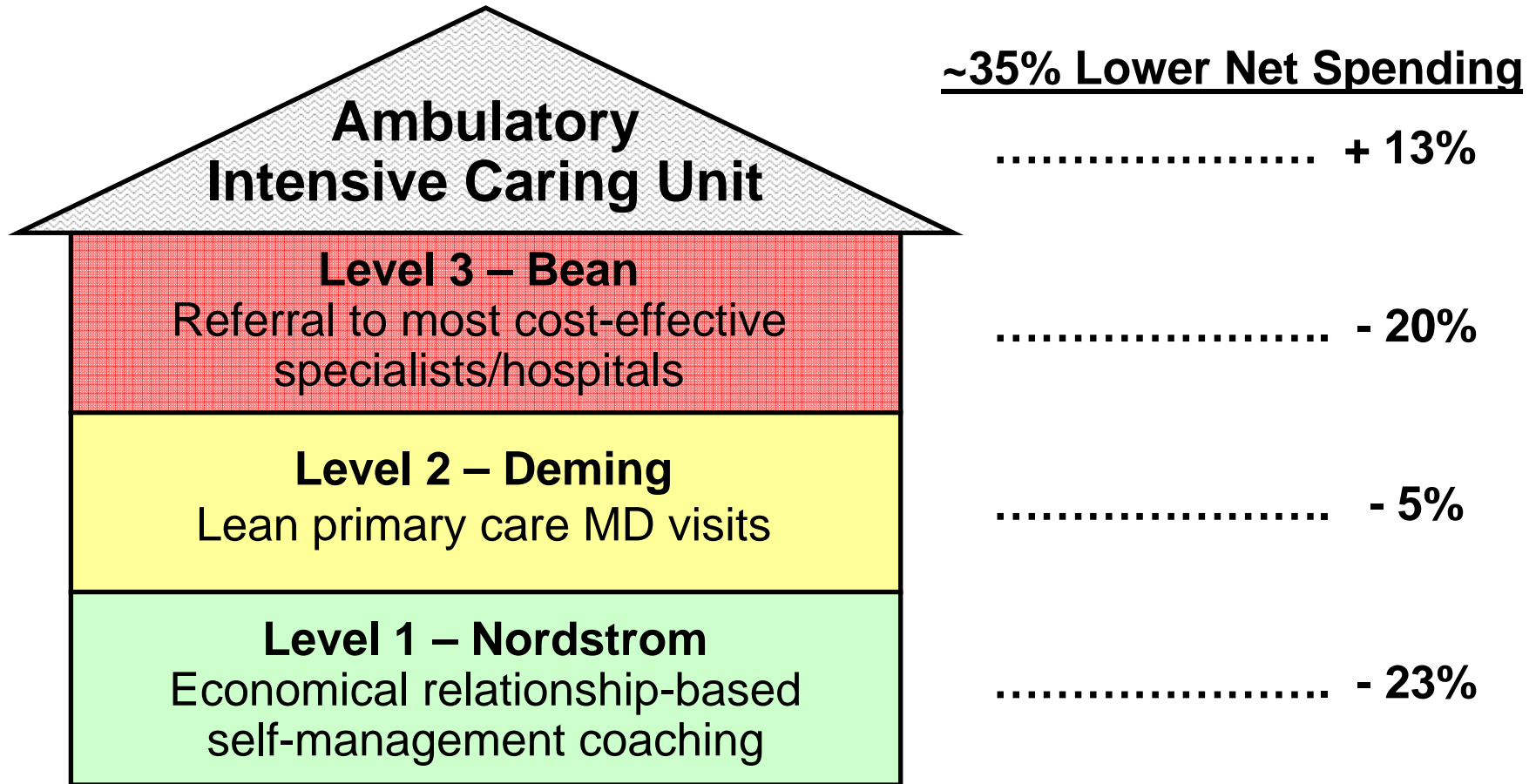


## Potential Knowledge Turns to Lower Total Cost of Care

- **Offshoring major surgeries (1 percentage point net savings?)**
- **Electronic visits with offshore MDs (2 percentage point net savings?)**
- **“Ambulatory ICU”/medical home for sickest quintile (20 percentage point net savings?)**



# An Ambulatory Care "ICU" for Predicted Highest Cost Quintile of Plan Enrollees: Testing in Five Locations in 2007



Source: California HealthCare Foundation 2005 report



# To Lower Total Cost of Care, What Sacred Cows *External* to Care Delivery Processes Must be Sacrificed?



**Efficiency  
Measures and  
Measurements  
Must Meet  
Rigorous  
Standards of  
Scientific  
Acceptability**



**If Efficiency  
Measures are not  
Produced by  
EHRs, Providers'  
Data Collection  
Cost Must be  
Reimbursed**



**Performance-  
Reward  
Formulas Must  
Sustain the  
Livelihoods of  
All Current  
Providers**



# To Lower Total Cost of Care, What Sacred Cows *Within* Care Delivery Processes Must be Sacrificed?



**Tacit Complicity  
in Patient Self-  
Management  
Failures**



**MD as Primary  
Performance  
Lever (Rather  
Than Teams and  
Systems)**



**100%  
In-Country  
Health Care  
Workforce**



## ↑↑ MD Accountability for Efficiency Will Challenge Physician Solidarity

**“As we think about failure to conserve ‘the commons’ of pooled health insurance resources, the primary care physicians are picking blades of grass one-at-a-time. The specialists have lawnmowers.”**

**– George Isham, MD  
HealthPartners**



## A Constructive Vision of the Path Forward in Physician Accountability for Efficiency

- **We have a common problem**
- **It is understandable**
- **It is solvable**
- **Solving it will require leadership, commitment and a willingness on the part of each sector to forego its narrow interests**

– ABIM, September 2006



## Closing Thoughts for Aspiring Shark Tamers

- **Middle income households are now being eaten; they need two new jobs to be done**
- **A voluntary “700 Billion Bucks Saved Campaign” won’t succeed**
- **Both relevant IOM recommendations are important: include efficiency measurement at every level of provider aggregation; and prioritize efficiency measurements in P4P**
- **Efficiency breakthroughs will require sacred cow sacrifice**
- **“Plan B” is much worse...and avoidable**